DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 1

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.53 through 447.54
42 CFR 447.331 and 42 CFR 447.332

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 193,954
b. FFY 2002 $ 384,005

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 3.1-A, pp 5a, 5a.1
ATTACHMENT 4.19-B, pp. 2, 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 3.1-A, pp 5a
ATTACHMENT 4.19-B, pp 2, 2a

10. SUBJECT OF AMENDMENT:
CLARIFICATION OF THE DEPARTMENT'S USUAL AND CUSTOMARY PHARMACY BILLING POLICY TO UPDATE THE DISPENSING FEE AND DESCRIBE THE PROPOSED NEW CO-PAY LOGIC

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mark Trail

14. TITLE:
Acting Director, Division of Medical Assistance

15. DATE SUBMITTED:

16. RETURN TO:
Georgia Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
February 2, 2001

18. DATE APPROVED:
June 11, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
June 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: **Associate Regional Administrator**
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

12a. **PRESCRIBED DRUGS**

Limitations

Pharmacy services will be provided to recipients under age 21 for medically accepted indications when these services are provided within the laws and regulations governing the practice of pharmacy by the State.

Effective November 1, 1991, the Department will pay for no more than six (6) prescriptions, new or refills, per recipient under twenty-one (21) years of age and no more than five (5) prescriptions, new or refills, per recipient over 21 years of age per calendar month unless an exception has been obtained to exceed the limit, or the physician documents that the prescription was for an emergency.

Covered Services

Drugs, for which Medical Assistance reimbursement is available, are limited to the following:

Covered outpatient drugs of any manufacturer that has entered into and complied with an agreement under Section 1927(a) of the Act, which are prescribed for a medically accepted indication.

As provided by Section 1927(d)(2) of the Act, certain outpatient drugs may be excluded from coverage. Those excluded are:

(1) agents used for anorexia or weight loss;
(2) agents used to promote fertility;
(3) agents used to promote smoking cessation;
(4) agents used for cosmetic purposes or hair growth;
(5) barbiturates, except Phenobarbital, Secobarbital and Mebaral;
(6) non-prescription drugs with the following exceptions: Enteric coated aspirin (covered under nursing home per diem), meclizine, iron, multivitamins, insulin and diphenhydramin; Nix; pen-X; syringes and urine test strips
(7) prescription vitamins and mineral products, except prenatal vitamins and flouride products that are not in combination with other vitamins and Carnitor;
(8) covered outpatient drugs which the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;
(9) drugs described in Section 107(c) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal regulations (DESI drugs), under 1927 (d)4.
(10) effective November 1, 1991, cough and cold medications will not be covered for recipients over twenty-one (21) years of age. The Department defines cough and cold medications to be antihistamine/decongestant combination drugs, antitussives and expectorants.
(11) effective April 1, 1995, the following medications are covered for ESRD patients only when the physician has certified them for a medically accepted indication through the prior approval process. These drugs are exempt from the monthly prescription limit. All strengths and dosage forms of each OTC drug entity are covered with some exceptions. Covered drugs include: Calcium carbonate, aluminum hydroxide, calcium acetate, calcium carbonate with glycine, calcium lactate, dioctyl sodium/calcium sulfosuccinate, niacin, pyridoxine hydrochloride, thiamine hydrochloride, vitamin B Complex, cyanocobalamin (injection for pernicious anemia only), vitamin D, Hectoral, and Renagel.

12a. PRESCRIBED DRUGS (continued)

(12) topical Vitamin A derivatives for recipients > 21 years old.

(13) agents prescribed for any indication that is not medically accepted, under 1927(d)(1)(B).

(14) drugs from non-participating rebate manufacturers, under 1927(1).

(15) effective January 1, 1992, Benzodiazipines for recipients twenty-one (21) years of age and over except as described in the Policies and Procedures Pharmacy Services Manual.

No payment will be made for innovator multiple source drugs for which federal upper limits have been established, unless the physician has certified that the brand is medically necessary in his own handwriting on the prescription.

Prior Approval is required for recipients to obtain certain types of drugs with therapy limitations and for certain drugs prior to dispensing.

Effective July 1, 1991, prior authorization is provided through a vendor contractual agreement within a twenty-four (24) hour turnaround from receipt of the request for drugs with limitations or which require prior approval before dispensing.

Effective July 1, 1998, the pharmacist may enter an appropriate override at the point of sale to exceed the monthly prescription limit for the drugs deemed medically necessary by the prescriber.

Drug Rebate Agreement

- The State will comply with the reporting requirements for State utilization information and on restrictions to coverage.
- If the State has existing supplemental agreements, these will operate in conformance with law; while new agreements will require HCFA approval. The State agrees to report rebates from separate agreements.
- The State will allow manufacturers to audit utilization data.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

d. Prescribed Drugs

1. Medicaid pays for prescribed legend and non-legend drugs authorized under the program. Reimbursement for covered multiple source drugs shall not exceed the lowest of:

   (a) The federal mandated upper limit for certain multiple source drugs as established and published by HCFA plus a reasonable dispensing fee as established in item 2; or
   (b) The Georgia Maximum Allowable Cost (GMAC) as established by the Department for additional multiple source drugs plus a reasonable dispensing fee as established in item 2 below; or
   (c) The Georgia Estimated Acquisition Cost (GEAC) for multiple source drugs plus a reasonable dispensing fee as established in item 2 below; or
   (d) The usual and customary charge as defined below by the Department for the prescription.

   Reimbursement for covered drugs other than multiple source drugs shall not exceed the lower of:

   (a) The GEAC for all other drugs plus a reasonable dispensing fee as established in item 2 below.
   (b) The usual and customary charge as defined by the Department for the prescription.

   GEAC is defined as the average wholesale price (AWP) of the drug less a 10% discount for all drugs

   The Department defines usual and customary as the lower of the lowest price reimbursed to the pharmacy by other third party payers (including HMOs); or the lowest price routinely offered to any segment of the general public. Donations or discounts provided to charitable organizations, or fees charged to or paid by federal or state funded programs are not considered usual and customary charges.

2. The dispensing fee for profit and non-profit community pharmacies is based on periodic surveys of pharmacy operating costs including professional salaries and fees, overhead costs and reasonable profit. Between these periodic surveys, the Department, in consultation with the Pharmacy Advisory Committee and the Governor's Office of Planning and Budget, reviews the fee. When appropriate, the fee is adjusted based on an inflation factor. The current fee is $4.63 for profit pharmacies and $4.33 for non-profit pharmacies. Effective on or after June 1, 2001, the Medicaid dispensing fee shall be $4.63 for profit pharmacies and $4.33 for non-profit pharmacies for each non-generic or non-preferred drug dispensed by the pharmacy; and $5.13 for profit pharmacies and $4.83 for non-profit pharmacies for each generic or preferred drug dispensed by the pharmacy. The dispensing fee paid by the Department shall be subject to the usual and customary charge as defined by the Department above.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
FOR OTHER TYPES OF CARE OR SERVICES

d. Prescribed Drugs (continued)

A. Exception: Effective July 1, 1996, the Department will encourage the use of multiple source drugs. The innovator brand or a multiple source drug may be dispensed for a medically accepted indication.

3. No dispensing fee is allowed to the physician dispensing drugs.

4. Payment for special approved drugs as requested by the prescribing physician is determined as in 1. above.

5. Prescriptions supporting Medicaid claims must be initiated and recorded in accordance with State and Federal laws. The maximum quantity payable for a prescription or its refill will be one (1)-month supply.

6. Effective with the date of service on or after June 1, 2001, the Department will impose a co-payment for each non-preferred or non-generic prescription drug dispensed to a Medicaid recipient based on the typical payment by the Department for the prescription as follows:

Cost to State	Co-Payment
$10.00 or less	$0.50 co-payment
$10.01 to $25.00	$1.00 co-payment
$25.01 to $50.00	$2.00 co-payment
$50.01 or more	$3.00 co-payment

Recipients under age twenty-one (21), pregnant women, institutionalized individuals, and hospice care recipients are not required to pay this co-payment. Emergency services and family planning services are also exempt from this co-payment. The Department will impose a nominal co-payment of $.50 for each generic or preferred prescribed drug dispensed by the pharmacy.